E M P L O Y E E G U I D E

Understanding Your Medical & Dental Coverage

E F F E C T I V E J A N U A R Y 1 , 2 0 0 0

HCA 50-100 (11/99)

Questions?

Medical Plans	Urgent care facilities?	Wellness education classes?	24-hour nurse advice line?	Web site address	Customer service phone numbers
Aetna USHC	✔		✔	www.aetnaushc.com	1-800-756-7039 TTY/TDD same as above
CHPW		✔	✔	www.chpw.org	206-521-8830 or 1-800-440-1561 TTY/TDD 1-800-833-6388
Group Health Cooperative	✔	✔	✔	www.ghc.org	206-901-4636 or 1-888-901-4636 TTY/TDD 206-901-4602
Kaiser	✔	✔	✔	www.kaiserpermanente.org	1-800-813-2000 or Portland: 503-813-2000 TTY/TDD 1-800-324-8007
NW WA Medical Bureau	✔	✔			Bellingham: 1-800-825-5962 x290 Mt. Vernon: 1-800-659-7229 x4 TTY/TDD 360-650-1454
Options	✔	✔	✔	www.ghc.org	206-287-2100 or 1-800-542-9172 TTY/TDD 206-442-4107
PacifiCare	✔	✔		www.pacificare.com	1-800-932-3004 TTY/TDD 1-800-257-5799
Premera Blue Cross/MSC	✔	✔		www.premera.com	509-536-4500 or 1-800-572-0778 TTY/TDD 1-800-291-4145
Premera HealthPlus	✔	✔	✔	www.premera.com	425-771-3111 or 1-800-527-6675 TTY/TDD 1-800-842-5432
RegenceCare			✔	www.wa.regence.com	206-340-6610 or 1-800-376-7926 TTY/TDD 206-389-6728
UMP				www.wa.gov/hca/ump	425-670-3000 or 1-800-762-6004 TTY/TDD 1-888-923-5622

Dental Plans	Customer service phone numbers
DeltaCare, administered by Washington Dental Service	1-800-537-3406
Regence BlueShield Columbia Dental Plan	1-800-258-2035
Uniform Dental Plan, administered by Washington Dental Service	1-800-537-3406

Public Employees Benefits Board	Web site address	Customer service phone numbers
General Information About Your Coverage	www.wa.gov/hca	1-800-700-1555 Olympia: 360-412-4200
Questions About Appeals		360-923-2625

Contents

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What You Need To Know

Welcome to State Service

The Washington State Health Care Authority (HCA) is the agency responsible for the purchase and coordination of health insurance benefits for state employees through Public Employees Benefits Board (PEBB) plans. This guide provides you with some basic information about your medical and dental coverage and will help you choose a health plan.

The benefits described in this guide are brief summaries. For a complete description of your benefits, refer to the plan's certificate of coverage (benefits booklet). You will receive your certificate of coverage directly from your plan after you enroll.

Some benefits described in this booklet are based on state laws. We have attempted to describe them accurately, but if there are differences, the laws will govern.

How to Enroll

You must enroll yourself and your eligible dependents in a PEBB medical and dental plan within 31 days of the date you first become eligible to apply for employer-paid benefits under PEBB rules. Enrollment forms are furnished by your payroll, personnel, or benefits office and must be returned to that office within 31 days. If you fail to submit an enrollment form within that period, you will be enrolled in the Uniform Medical and Dental Plans as a single subscriber. Claims for benefits under those plans will be denied until you submit a completed enrollment form. Your next opportunity to change plans or add dependents will be the next open enrollment period. For exceptions, refer to pages 3 and 4.

Subscribers and all eligible dependent family members must be covered under the same PEBB medical and dental plan. If both you and your spouse are eligible employees, you may enroll as subscribers in the same plan or different plans and may each cover eligible dependent family members. Verification of the dependency status of anyone enrolled under your PEBB coverage may be requested at any time by the HCA or the participating plans.

It is your responsibility to be informed about your benefits. To avoid penalty or loss of benefits, please note all requirements for use of providers, preauthorization, and medical review specified in each plan's certificate of coverage.

When you fill out your enrollment form, you will be asked to select a medical and a dental plan. Follow these steps to join a plan:

1. Read this guide.
2. Check to see which medical plans are offered in your area. See the "Plan Availability by County" section of the HCA Web site.
3. Gather information.

a) Read about the medical and/or dental plans that interest you. See the "Medical Benefits" section of the HCA Web site, health plan information on the inside front cover, and the "Dental Plans" section on page 14.

b) Find out about the plans' costs. Some plans require contributions toward coverage for you or your children. All of the plans require you to pay at least $10 per month to cover your spouse. See the "2000 Monthly Employee Rates" section of the HCA Web site. Employee contribution information is also enclosed in your new employee packet or can be obtained from your personnel, payroll, or benefits office.

c) Call the plans to request a list of their providers or ask questions. You can verify that your provider participates with the medical plan you choose by checking the provider directory on the HCA Web site at www.wa.gov/hca or by calling the plan directly. If you are choosing a doctor or other provider for the first time, be sure to find out if he or she is accepting new patients.

4. Choose your medical/dental plan. There are no restrictions or waiting periods for pre-existing conditions under any of the PEBB medical plans.

5. Complete the enrollment form and return it to your payroll office or the person in your agency who handles benefit changes within 31 days of the date you become eligible to apply. Call the HCA at 360-412-4200 or 1-800-700-1555 if you need help completing the enrollment form.

Identification Cards

After you enroll, you'll receive an identification card from your plan. Show this card to your providers when you receive care. If you have any questions about your identification card, contact your plan directly. (The Uniform Dental Plan does not issue identification cards.)

Waiving Medical Coverage

You or your eligible dependent(s) may waive PEBB medical coverage. If you waive medical coverage, you will still continue dental, life, and long-term disability coverage. You cannot waive coverage for yourself and continue to provide coverage to your dependents.

To waive medical coverage, you must sign the "Waiver of Medical Coverage" section of the enrollment form, indicating you have other health care coverage.

If you have other coverage, you may want to look up the coordination of benefits rules for your other coverage and compare the advantages and disadvantages of participating in one or both plans.

Once you waive medical coverage, you may enroll in PEBB medical coverage midyear if you show proof that you had other continuous coverage and you do so within 31 days of the date you lose your other coverage. You may re-enroll during the annual open enrollment period without proof of continuous coverage. However, K-12 employees may not be permitted by their school district to re-enroll until the next open enrollment or renegotiation period.

The employee and his or her dependents may have an additional opportunity to enroll if he or she has a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage, or within 60 days of birth, adoption, or placement for adoption.

Effective Dates of Coverage

◆ **New employees**
If you're eligible, your coverage begins on the first of the month following the date of employment. If your employment begins the first working day of the month, coverage begins on that day. This applies to permanent, seasonal, and career seasonal/instructional employees. Coverage will extend through the last day of the month in which your employment ends. There are exceptions for certain employee groups (see "Eligibility" section on page 5 for definitions):

◆ **Nonpermanent employees** Coverage begins on the first day of the month following six consecutive months of employment at a level of half-time or more.

◆ **Part-time faculty** Coverage begins on the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.

◆ **Appointed and elected officials** Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of a month, coverage begins on the first day of their term.

Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of government, and judges, on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins or the oath of office is taken.

◆ School district employees The effective date is determined by the terms of employment or collective bargaining agreement. Participation of the bargaining unit or non-represented employees is subject to approval by the HCA.

◆ Employees returning from leave If medical premiums were self-paid, employer contributions for PEBB coverage will begin the first of the month in which the employee returns to work. If an employee has self-paid premiums for any month in which he or she is eligible for premium contribution by his or her employer, the employee will be reimbursed any self-paid premium payment.

If a break in coverage occurred because medical premiums were not self-paid, coverage will begin the first of the month following return to work.

◆ New dependents Coverage for newborns and newly adopted children begins on the date of birth or the date you assume legal obligation for support in anticipation of adoption. Coverage for other new dependents (e.g., spouse or stepchild) begins on the first of the month following his or her eligibility date. (Please refer to "Adding and Dropping Dependents" to find out how to enroll your dependents in PEBB coverage.) If you enroll in a plan that charges for children and your child is born or adopted before the 16th of the month, you will be charged the full month's premium. You will not be charged until the following month for children born or adopted on or after the 16th of the month.

If a newly eligible subscriber or dependent other than a newborn child is confined in a hospital, skilled nursing facility, approved chemical dependency treatment facility, or other inpatient facility when coverage would normally begin, no benefits will be provided for services rendered before discharge.

Changing Your Plans

Open enrollment is the period set aside each year for you to change health plans, add dependents, or enroll in a medical plan if you have previously waived coverage. In most cases, you are not allowed to change plans except during open enrollment. Your coverage remains in effect for an entire year (until December 31) unless your employment with the state ends or you waive your medical coverage. However, you may be able to change plans during the plan year in the following situations:

If your doctor, dentist, or health care facility discontinues participation in your plan, you may not change plans until the next open enrollment period. Also, if you transfer from one agency or school to another during the plan year, you are not permitted to change plans, except as explained in "Changing Your Plans."

◆ If you move, you may change your plan under the following conditions: Plan changes must be submitted within 31 days of the move date. If you move from your plan's service area, you must enroll in a plan available in your new locality, or if a plan has not been available to you and you move into that plan's service area, you may enroll in that plan. All such plan enrollment changes take effect on the first day of the month following the date you move. Please contact your payroll, personnel, or benefits office if you have an address change.

◆ If a court order requires you to provide medical coverage for an eligible spouse or child, you may change medical plans and add the dependent. The change is effective the first day of the month following the enrollee's notification or the date of the application.

◆ If you retire, you may change plans at the time you apply for retiree coverage. The change is effective the first day of the month following the date your active employment ends.

◆ Seasonal employees whose off-season occurs during open enrollment may change plans within 31 days of returning to work.

To initiate a plan change under any of the above listed circumstances, contact the payroll, personnel, or benefits office where you work.

Adding and Dropping Dependents

You may add eligible dependents midyear if you have a qualifying change in family status. See "Eligibility" on page 5 for a list of eligible dependents, and refer to your plan's certificate of coverage for time limitations. Changes in family status include:

- Marriage.
- Birth, adoption, or placement of a child for adoption.
- The loss of other continuous medical coverage for dependents who have previously waived coverage.

Dependents must be enrolled within 31 days of eligibility, except in the following situations:

- Newborns or newly adopted children must be enrolled within 60 days of eligibility if addition of the new dependent increases your monthly premium.

When a new dependent becomes enrolled before the 16th day of the month, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.

- Dependents who lose other medical coverage must enroll in a PEBB plan within 31 days of the date their other coverage ends. Dependents will be required to provide proof of continuous health-care coverage up to the time their other coverage terminates. If the dependent meets enrollment criteria, PEBB-sponsored coverage will begin the first day of the month after the other coverage is terminated.

If you want to add dependents, return a completed application to your payroll, personnel, or benefits office or the person in your agency who handles benefit changes within the time limits previously described. Otherwise, you must wait until the next annual open enrollment period to make the change.

You may also cancel dependent coverage midyear when you have a change in family status. You must notify your payroll, personnel, or benefits office and cancel your dependent coverage in the following situations:

- Your spouse (upon divorce)
- Your spouse or child (upon his or her death)
- Your children (upon their reaching the age limits for participation; see "Dependents" on page 5)
- Your spouse or children (when they no longer meet the definition of an eligible dependent)

Important! Employees that have waived medical coverage for themselves or family members may have an additional opportunity to enroll in medical coverage. If you have a qualifying change in family status—marriage, birth, adoption, or placement for adoption—you may enroll members that previously waived coverage, provided that enrollment is requested within 31 days of marriage or within 60 days of birth, adoption, or placement for adoption. For example, if you have a birth, you may also enroll your spouse who previously waived medical coverage as long as you request the enrollment within 60 days from the child's birth date. However, you may not change medical or dental plans.

Eligibility

Employees

The following employees of state government, higher education, K-12 school districts, educational service districts, political subdivisions, and employee organizations representing state civil service workers are eligible to apply for PEBB coverage in accordance with WAC 182-12-115 (for information on when coverage begins, see "Effective Dates of Coverage" on page 2):

◆ **Permanent Employees**
If you work at least half-time per month and are expected to be employed for more than six months, you are eligible to apply for coverage on the first day of your employment.

◆ **Nonpermanent Employees** You are a nonpermanent employee if you work at least half-time and are expected to be employed for no more than six months. If your employment continues beyond the initial six-month period, you may apply for coverage on the first day of the seventh calendar month of employment.

◆ **Seasonal Employees** If you work at least half-time per month during a designated season for a minimum of three months but fewer than nine months per year, and you have an understanding of continued employment with state government season after season, you may apply for coverage on the first day of employment. You are not eligible for the employer contribution during the break between seasons of employment, but may be eligible to continue coverage by self-paying premiums.

◆ **Career Seasonal/ Instructional Employees** If you work half-time or more on an instructional year (school year) or equivalent nine-month seasonal basis, you may apply for coverage on the first day of employment. You are eligible for the employer contribution for health care coverage during the off-season following each period of seasonal employment.

◆ **Part-Time Faculty** If you are employed on a quarter/semester to quarter/semester basis of half-time or more employment at one or more state institutions of higher education, you may apply for coverage at the beginning of the second consecutive quarter/semester of employment. For purposes of determining eligibility, spring and fall are considered consecutive quarters/ semesters.

◆ **Appointed and Elected Officials** If you are a legislator, you may apply for coverage on the date your term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible to apply for coverage on the date their term begins or when they take the oath of office, whichever occurs first.

◆ **Judges** If you are a justice of the Supreme Court, or a judge of the Court of Appeals or the Superior Courts, you are eligible to apply for coverage on the date you take the oath of office.

◆ **School District and Political Subdivision Employees**
If you are a Washington State school district or political subdivision employee, you may apply for PEBB coverage if the PEBB plans are the only medical plans offered through your employment and:

- The eligible members of a bargaining unit enroll as a unit, and the unit is approved for participation by the HCA, or
- All non-represented eligible employees enroll as a group, and the group is approved for participation by the HCA.

Employee eligibility is determined by the bargaining unit contract or terms of employment. For more information about employee eligibility, see your plan's certificate of coverage.

Dependents

If you are enrolled in a medical and/ or dental plan, you may also enroll the following dependents in the same plan(s):

◆ Your lawful spouse.

◆ Your dependent children through age 19. The term "children" includes your natural children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support in anticipation of adoption of the child, or children specified in a court order or divorce decree.

Married children who qualify as your dependents under the Internal Revenue Code and additional legal dependents approved by the HCA are included.

Dependent children who are full-time students or who are developmentally or physically disabled are eligible beyond age 19 under the following conditions:

◆ Students age 20 through age 23 are eligible if they are: (i) dependent on you for maintenance and support, and (ii) are registered and attend full-time an accredited secondary school, college, university, vocational school, or school of nursing. Coverage of dependent students continues year-round for those who attend three of the four school quarters and for three full calendar months following graduation as long as you are covered at the same time.

◆ Dependent children of any age are eligible if they are incapable of self-support due to developmental or physical disability, provided that their condition occurred before age 20 or during the time they were covered under a PEBB plan as a full-time student. Proof of such disability and dependency must be provided to the HCA upon application and as periodically requested thereafter.

◆ Your dependents who were previously covered under a K-12 health plan and who are not otherwise eligible for PEBB coverage may continue coverage under a PEBB plan for up to 36 consecutive months. To be eligible for this continuation of coverage, the PEBB plan must be immediately replacing a K-12 health plan with no lapse in coverage.

If your child is enrolled in a college out of your plan's service area, he or she may receive network-level benefits through any licensed provider. However, benefits are administered differently from plan to plan. Contact your plan for details.

◆ If your dependent loses eligibility under a PEBB plan for active employees due to your death, your dependent(s) may continue coverage under a retiree plan provided he or she will immediately begin receiving a monthly benefit from a state of Washington-sponsored retirement system as listed in the answer to question three in the "Questions and Answers" section on page 7.

Medicare Eligibility

For active employees and their spouses age 65 and older, PEBB-sponsored medical plans will provide primary coverage, and Medicare coverage will be secondary. However, active employees 65 and older may choose to reject PEBB-sponsored medical coverage and choose Medicare as their primary insurer. If you do so, you will receive no PEBB coverage. The HCA can provide you with more information.

In most situations, active employees and their spouses can elect to defer Medicare Part B enrollment, without penalty, up to the date the employee terminates or retires. Upon retirement, Medicare will become the primary insurer, and the PEBB-sponsored medical plan becomes secondary.

Questions and Answers

Covering Dependents

1 Is my dependent eligible?

A If you are enrolling yourself, you may also enroll your legal spouse and eligible children. See the "Eligibility" section on page 5 for the definition of eligible children.

2 If one of my children attends college full-time, can I still enroll in a managed care plan that is not offered in the county in which he or she goes to college?

A Yes, although most managed-care plans require that you permanently reside within the plan's service area in order to enroll. If one or more dependents live outside your plan's service area temporarily while attending an accredited secondary school, college, university, vocational school, or school of nursing full-time, they may receive benefits through any licensed physician. Claims for those providers will be paid as if the service had been received through plan-designated providers. The dependents will be responsible for the same copayments that apply to in-area enrollees. For purposes of preauthorization, the plan will assume the role of the primary care provider. The plan must authorize all services in advance (including routine care), except when emergency or urgent care is needed.

3 If I die, can my surviving dependents continue PEBB coverage?

A If you die, medical and dental coverage may continue for your covered dependent(s) for up to 36 months under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Contact the HCA for details.

Your dependent's coverage may continue if you die and your covered dependent(s) immediately receives a monthly benefit from one of the following retirement systems sponsored by the state of Washington:

- Public Employees Retirement System (PERS I or II)
- Teachers' Retirement System (TRS I, II, or III)
- Law Enforcement Officers' and Fire Fighters' Retirement System (LEOFF I or II)
- State Judges/Judicial Retirement System
- Washington State Patrol Retirement System
- Higher Education Retirement Plans
- School Employees Retirement System (effective September 1, 2000)

In this situation, your spouse's coverage continues indefinitely, as long as premiums are paid. Other dependents may continue coverage until they are no longer eligible under PEBB rules. See the "Dependents" section on page 5 for details.

Your dependent(s) must apply for surviving dependent coverage within 60 days from the day you die.

4 What if my enrolled child becomes ineligible during the year?

A Contact your personnel, payroll, or benefits office. This will be particularly important if you are paying a monthly premium for your dependent's coverage. In addition, your child may be eligible to continue coverage under COBRA. See your plan's cerificate of coverage for details.

Continuing Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that most employers sponsoring group plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates should coverage end because of certain "qualifying events." If you have the right to continue group coverage, you must enroll within 60 days and you'll need to pay your own premiums. COBRA rates exceed other self-pay rates by 2 percent. See your plan's certificate of coverage for details.

5 What should I do if my spouse is also eligible for PEBB coverage as an employee?

A Both of you should enroll in PEBB plans as employees and then determine whether it makes sense for you to also enroll as a spouse under each other's plan.

- If you both sign up for the Uniform Medical Plan (UMP), it is generally not worth enrolling in spousal coverage because of the plan's non-duplication of benefits provision.
- If both of you sign up for one of the other managed care plans, your choice depends on how much you expect to spend in copays for medical services for the year.
- If one of you enrolls in a managed care plan and the other enrolls in the UMP, the situation is more complicated due to differences in coordination of benefits. Spousal coverage may be beneficial in some situations.

Call a PEBB benefits specialist at 360-412-4200 or toll-free at 1-800-700-1555 for answers to your specific questions.

Pre-Existing Conditions

There are no pre-existing condition restrictions or waiting periods for any PEBB-sponsored medical or dental plan.

Selecting a Plan

6 What plans are available?

A The HCA offers a total of 11 medical plans and three dental plans. Not all the plans are available in every county. In most cases, you must live in the plan's service area to join the plan. For more information about the medical plans offered in your county, review the "Plan Availability by County" section of the HCA Web site. To find out where the dental clinics are located that are available through PEBB dental plans, see page 14.

7 How do I select the best plan for me and my family?

A Only you can decide which plan makes the most sense for you and your family. If you cover eligible dependents, they must be covered under the same medical and dental plan you choose.

As you review the plans, here are some things to consider:

- **Geography** In most cases, you must live in the plan's service area to join the plan. If you are not sure about a particular plan's service area, call the plan directly. Medical and dental plan phone numbers are listed on the inside front cover.
- **Cost** You may share in the cost of coverage if you choose a plan with a monthly premium or cover your spouse. Keep in mind, higher cost doesn't necessarily mean higher quality of care or higher benefits; most plans have the same basic level of benefits.
- **Unique medical needs** If you or a family member have a chronic health problem, or if you'll need certain medical care, you may want to choose a plan that provides the optimum benefits and coverage for the needed treatment, medications, or equipment. Contact the plans directly with questions about your unique medical needs.
- **Coinsurance vs. copays** Managed care plans described in this guide require that you pay a fixed portion (called a "copay" or "copayment") at the time you receive network care. Under the Uniform Medical Plan, the enrollee is responsible for a coinsurance (percentage of an allowed fee). A coinsurance is also applied to managed care extended-network benefits in addition to the copay.
- **Deductible** The Uniform Medical Plan requires that an annual deductible be satisfied before the plan begins reimbursing for covered services (preventive care and certain other benefits are exempt from the UMP deductible). Many extended network managed-care plans also have an annual deductible when you receive care from an extended network provider.

◆ **Out-of-pocket maximum** In general, this is the maximum amount you pay in one calendar year. Once you pay this amount, most plans pay 100 percent for most covered services for the remainder of the calendar year. Most managed care plans have a $750 per person and $1,500 per family out-of-pocket maximum. The Uniform Medical Plan and extended network managed-care plans have different out-of-pocket limits. For a list of expenses that apply to the out-of-pocket maximum, see the definition of "annual out-of-pocket maximum" in the glossary.

◆ **Referral procedures** Some plans allow you to self-refer to any network provider; others require that you have a referral from your primary care provider. (Due to changes in state law, you can self-refer to a participating provider for women's health care services. Contact your plan for further information, including limitations and restrictions.)

◆ **Your provider** If you have a long-term relationship with your doctor or health care provider, you may want to see if your provider is a primary care provider in the plan's network before you join.

◆ **Paperwork** In general, the plans described in this guide don't require you to file claims. However, you may need to file a claim if you select a plan with extended network benefits and see an extended network provider or if you enroll in the Uniform Medical Plan and see a nonpreferred provider.

◆ **Coordination with your other benefits** See "Coordination of Benefits" on page 10 for more information.

8 How do the plans differ?

A All medical plans offer the same basic benefits, although benefit enhancements, limitations, payroll deductions, and out-of-pocket maximums may vary. The "Medical Benefits" section of the HCA Web site and information on the inside front cover summarize some of those differences. For more information, call the plans directly or review the plans' certificates of coverage.

Cost

9 How will I know how much the plans cost?

A Employee monthly rate information is enclosed in your new employee packet or can be obtained from your personnel, payroll, or benefits office. The information will itemize the amount of money that will be deducted from your paycheck each month, according to the size of your family and the plan you choose.

Providers

10 How do I know if my doctor or hospital belongs to a plan?

A Simply ask your doctor or hospital, or check the online provider directory on the HCA's Web site (www.wa.gov/hca). You can search for PEBB providers by name, clinic or office location, and health plan. Be sure to contact the health plan or provider to verify whether the provider you are interested in is accepting new patients. The plan phone numbers are listed on the inside front cover. *Be sure you let them know you are a PEBB state of Washington enrollee.* Chances are that your provider or hospital participates in one or more of the PEBB plans.

11 May I change providers after I have joined a plan?

A Rules vary from plan to plan, but all plans have a process for making changes. Check with your plan for more information.

Paying With Pretax Dollars

If the plan you choose requires a monthly premium, you pay for your coverage with pretax dollars. This means the amount you pay toward your coverage is deducted before federal and most state income taxes are calculated. By paying for your coverage this way, you reduce your taxable income, which lowers your taxes and saves you money (applicable to state employees only).

12 Do all members of my family have to use the same provider?

A They may select the same provider, but it's not required. Each member of your family may select his or her own medical provider available through the plan. Some dental plans require selection of one dentist for the entire family.

Changing Your Coverage

13 When may I change plans?

A See page 3.

14 May I drop my dependent from coverage midyear?

A Yes. You may drop coverage for your dependents at any time during the year. However, if your dependent needs to enroll in PEBB coverage outside of open enrollment, he or she must provide proof of continuous health care coverage or wait until the next open enrollment to enroll.

15 How do I enroll a new spouse or child?

A It is your responsibility to notify your payroll office or the person in your agency who handles benefit changes. You must submit a revised enrollment form to that person within 31 days of the qualifying event (60 days for a newborn or newly adopted child); otherwise, you must wait until the next open enrollment period to enroll your dependents. See "Adding and Dropping Dependents" on page 4 for more information.

Coordination of Benefits

16 How does my PEBB coverage work with my other group medical or dental coverage?

A **Coordination of benefits for the managed care plans.** Coordination of benefits means services could be covered up to 100 percent between the two plans combined.

Nonduplication of benefits for the Uniform Medical Plan (UMP) and Uniform Dental Plan (UDP). When the UMP or UDP is secondary to another insurance plan (which means your other coverage pays first), reimbursement is based on a method of calculation called "nonduplication of benefits." In general, this means the UMP or UDP will pay no more than it would have if it had been the primary plan, minus what the primary plan paid. Under certain circumstances, this may result in limited UMP or UDP payment. See the UMP or UDP certificate of coverage for details.

PEBB/HCA Administration

17 Who determines what the benefits will be?

A The Legislature takes the first step by setting the benefits funding level. The Public Employees Benefits Board (PEBB), created within the Health Care Authority (HCA), then establishes eligibility requirements and approves the benefits plans of all participating health care organizations. The PEBB meets regularly to review benefit and eligibility issues and conduct strategic planning. Refer to the "Contents" page in the front of this guide for a list of the board members.

18 Who administers the day-to-day operations of these programs?

A The Washington State Health Care Authority (HCA) is the state agency responsible for purchasing and administering benefits within the amount funded by the Legislature. The HCA contracts with health plans and manages its own self-insured plans, the Uniform Medical Plan and Uniform Dental Plan, to provide a choice of quality health care options and responsive customer service to its members.

General Medical Exclusions

Managed Care Plans

The following services and supplies are excluded from all PEBB-sponsored managed care plans. Plan-specific exceptions are noted. For further explanation of any exclusion, refer to the plan's benefits booklet.

1. Services not provided by a plan-designated or extended network provider or obtained in accordance with the plan's standard referral and authorization requirements, except for emergency care or as covered under coordination of benefits provisions
2. Services rendered outside the service area when the need for care could have been reasonably foreseen by the enrollee before leaving the service area, unless preauthorized by the plan
3. Experimental or investigational services, supplies, and drugs
4. That additional portion of a physical exam beyond a routine physical that is specifically required for the purpose of employment, travel, immigration, licensing, or insurance and related reports
5. Services or supplies for which no charge is made, or for which a charge would not have been made if the enrollee had no health care coverage or for which the enrollee is not liable; services provided by a family member (does not apply to Premera Blue Cross/MSC)
6. Drugs and medicines not prescribed by a plan-designated or extended network provider, except for emergency treatment
7. Over-the-counter drugs, except insulin, niacin, clotrimazole, diphenhydramine, chlorpheniramine, scabicides, or pediculicides prescribed by a plan-designated or extended network provider
8. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury
9. Convalescent or custodial care, or residential mental health treatment programs
10. Conditions caused by or arising from acts of war
11. Dental care including orthognathic surgery, nonsurgical treatment of temporomandibular joint (TMJ) dysfunction and myofacial pain dysfunction (MPD), and dental implants
12. Sexual reassignment surgery, services, and supplies
13. Reversal of voluntary sterilization
14. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and in vitro fertilization
15. Services and supplies provided solely for the comfort of the enrollee, except palliative care provided under hospice care
16. Coverage for an organ donor, unless the recipient is an enrollee of the plan
17. Medical services, drugs, supplies or surgery (such as but not limited to gastroplasty, gastric stapling, or intestinal bypass) directly related to the treatment of obesity
18. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies
19. Orthoptic therapy (eye training) and vision services, except as specified for vision care
20. Orthotics, except foot care appliances for prevention of complications associated with diabetes which are covered (orthotics covered by Premera HealthPlus)
21. Routine foot care
22. Contraceptive implants, such as Norplant (except Premera HealthPlus)
23. Services for which an enrollee has contractual right to recover cost, whether a claim is asserted or not, under automobile medical, personal injury protection, homeowner's, or other no-fault coverage
24. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records

25. Any medical services or supplies not specifically listed as covered

26. Direct complications arising from excluded services

27. Pharmaceutical treatment of impotence

Uniform Medical Plan (UMP)

The Uniform Medical Plan does not cover any of the following, nor can such charges be applied to any required plan deductible or out-of-pocket limit:

1. Services delivered by providers or facilities not listed as approved, or by providers or facilities delivering services of a type or in a manner not within the scope of their licenses

2. Any nonpreferred provider charges in excess of the plan's allowed charges

3. Experimental or investigational services, supplies, and drugs

4. That additional portion of a physical exam beyond a routine physical exam that is specifically required for the purpose of employment, travel, immigration, licensing, or insurance and related reports

5. Services or supplies for which no charge is made, or for which a charge would not have been made if the enrollee had no health coverage, or for which the enrollee is not liable; or services provided by a family member

6. Drugs and medicines not prescribed by an approved provider

7. Over-the-counter (OTC) drugs, except insulin, niacin, clotrimazole, diphenhydramine, chlorpheniramine, scabicides, pediculicides, or nicotine replacement therapy while participating in the Free and Clear Smoking Cessation Program; OTC drugs must be prescribed by an approved provider licensed to prescribe drugs

8. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury

9. Convalescent or custodial care, or residential mental health treatment programs

10. Conditions caused by or arising from acts of war

11. Dental care, including orthognathic surgery, nonsurgical treatment of tempormandibular joint (TMJ) dysfunction and myofacial pain dysfunction (MPD), and dental implants; services of a dentist except as provided in the "Office, Clinic, and Hospital Visits" benefit

12. Sexual reassignment surgery, services, and supplies

13. Reversal of voluntary sterilization

14. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and in vitro fertilization

15. Services or supplies that are provided solely for the comfort of the enrollee, except palliative care as specified in the "Hospice Care" benefit of the UMP benefits book

16. Coverage for an organ donor, unless the recipient is an enrollee of the UMP

17. Medical services, drugs, supplies, or surgery (such as, but not limited to gastroplasty, gastric stapling, or intestinal bypass) directly related to the treatment of obesity

18. Evaluation and treatment of learning disabilities, including dyslexia, except as provided in the "Neurodevelopmental Therapies" benefit of the UMP benefits book

19. Orthoptic therapy (eye training) and vision services, except as specified in the "Vision Care" benefit of the UMP benefits book

20. Routine foot care procedures; corrective shoes; treatment of fallen arches or symptomatic complaints of the feet; orthotics, and prescriptions thereof. Foot care appliances for prevention of complications associated with diabetes, however, are covered.

21. Contraceptive devices and implants such as Norplant

22. Services and supplies to the extent that benefits are available under any automobile medical, automobile no-fault, personal injury protection (PIP), commercial liability, commercial premises medical, homeowner's policy, or other similar type of insurance or contract, if the other insurance or contract covers medical treatment of injuries; however, plan payments will be advanced upon request if the enrollee agrees to apply for benefits under the terms of the other insurance and to reimburse this plan when settlement is received. For the purpose of this exclusion, benefits shall be deemed to be "available" to the enrollee if the enrollee is the named insured, comes within the definition of insured, or is a third-party beneficiary under the term of the policy.

23. Immunizations, except as provided in the "Preventive Care" benefit of the UMP benefits book

24. Treatment of neuropsychiatric, mental, or personality disorders, except as specified in the "Mental Health Care" benefit of the UMP benefits book

25. Acupuncture, except as provided in the "Miscellaneous Services" benefit of the UMP benefits book

26. Diagnosis and treatment of sexual disorders, except as provided in the "Durable Medical Equipment, Supplies, and Prostheses" benefit of the UMP benefits book

27. Massage therapy, except as provided in the "Physical, Occupational, and Speech Therapy" benefit in the UMP benefits book

28. Charges for educational programs, such as nutritional counseling for cholesterol control, except as provided in the "Diabetic Education" benefit and benefit #22 (stop smoking services) in the UMP benefits book

29. Charges for the extraction of and/or storage of autologous blood and its derivatives except when used for a covered peripheral stem cell rescue procedure

30. Court-ordered care, unless determined by the plan to be medically necessary

31. Wilderness training programs for chemical dependency

32. Services or drugs related to tobacco use and smoking cessation except as provided in benefit #22 (stop smoking services) in the UMP benefits book

33. Organ transplants and related services in nondesignated facilities

34. Charges for missed appointments, or completing or copying forms or records

35. Surgical treatment to alter the refractive character of the cornea, such as radial keratotomy and photo-keratectomy, and the results thereof

36. Manipulations of the spine and extremities, except as provided in the "Office, Clinic, and Hospital Visits" benefit of the UMP benefits book

37. Circumcision

38. Services received outside of the required case management plan except as provided in the "Required Case Management" section of the UMP benefits book

39. Treatment of learning disabilities after diagnosis, mental health custodial care, marital, family, sexual, or other counseling or training services, or care in a residential treatment facility

40. Services of a nonpreferred Certified Masters of Social Work (MSW), nonpreferred Certified Mental Health Counselor (CMHC), nonpreferred Certified Marriage and Family Therapist (CMFT), or non-Ph.D. psychologist except when employed by and delivering services within a community mental health agency

41. Any medical services or supplies not specifically listed as covered

42. Direct complications arising from any excluded services

43. Pharmaceutical treatment of impotence

Dental Plans

How the Dental Plans Work

You have three dental plans to choose from:

- *DeltaCare, administered by Washington Dental Service* is a managed-care dental plan that requires selection of one of their network dentists when you enroll. *Providers are located in* Arlington, Auburn, Ballard, Bellevue, Burien, Edmonds, Everett, Federal Way, Kent, Kirkland, Lakewood, Lynnwood, Mill Creek, Olympia, Puyallup, Redmond, Renton, Seattle, Silverdale, Spokane, Tacoma, Tukwila, Wenatchee, and Yakima, Washington.

- *Regence BlueShield Columbia Dental Plan*, a managed-care dental plan with services provided by Columbia Dental Group (CDG), requires that you receive care from CDG dentists. Their *clinics are located in* the following areas: Bellevue, Bellingham, Everett, Federal Way, Kent, Kirkland, Lynnwood, Northgate, Olympia, Puyallup, Seattle, Silverdale, Spokane, Tacoma, Tri-Cities, Tumwater, Vancouver, and Yakima, Washington.

- *The Uniform Dental Plan* allows you the freedom to choose any dentist, but gives you the opportunity to receive a higher level of reimbursement if your dentist is in the Washington Dental Service participating provider organization (PPO). The Uniform Dental Plan *offers services in every county of Washington State*. Outside of Washington State, services are reimbursed at a higher level than for services provided by non-PPO dentists in Washington State.

The table on the following page briefly compares the features of the Uniform Dental Plan and the managed-care dental plans described in this guide. Before enrolling in a managed-care dental plan, it is important to answer the following questions:

- Is the dentist I have chosen accepting new patients? (Remember to identify yourself as a PEBB state of Washington employee.)

- Am I willing to travel for services if I select a dentist in another service area?

- Do I understand that all dental care is managed through my primary care dentist or network provider, and I cannot self-refer for specialty care?

If the answer to these questions is yes, you may want to consider enrolling in a managed-care dental plan.

For full coverage provisions, including a description of limitations and exclusions, refer to a PEBB plan-specific booklet/certificate of coverage (available through the dental plans).

There are some differences between the dental plans:

- Benefits for emergency care received out of the plan's service area; missed appointment charges; and the number of exams, x-rays, cleanings, and other procedures allowed in a certain time period vary from plan to plan. Contact the plans directly for details. (Dental plan phone numbers are listed on the inside front cover.)

- If you are receiving continuous dental treatment (such as orthodontia) and are considering changing plans, contact the plans directly to find out how they cover your continuous dental treatment if you enroll in their plan.

Just Say "PEBB"

If you intend to join one of the managed-care dental plans, you'll want to be sure your dentist is a network dentist who contracts with PEBB. If you don't make sure he or she serves PEBB enrollees, you may be responsible for the cost of your care.

Please note: **Since clinic participation with the dental plans can change, please contact the dental plans to verify clinic locations.**

Comparison of the Dental Plans

	Managed-care dental plans: ■ *DeltaCare* ■ *Regence BlueShield Dental*	Participating provider organization: ■ *Uniform Dental Plan*
Annual deductible	No deductible	$50 per person/$150 per family, except for diagnostic and preventive
Annual maximum	No general maximum	$1,500 plan reimbursement per person; except as otherwise specified for orthodontia, nonsurgical TMJ, and orthognathic surgery
Dentures	$140 copay, complete upper; $40 copay, complete reline (chairside)	50%, PPO and out of state; 40%, non-PPO (dental plan payment)
Endodontics (root canals)	$50 copay, 1 canal; $125 copay, 4 canals	80%, PPO and out of state; 70%, non-PPO (dental plan payment)
Nonsurgical TMJ	70%; $500 lifetime maximum (dental plan payment)	70%; $500 lifetime maximum (dental plan payment)
Oral surgery	$0 copay, single extraction; $10 copay, each additional tooth Exception: *Regence*, $0 copay, each additional tooth	80%, PPO and out of state; 70%, non-PPO (dental plan payment)
Orthodontia	$1,500 maximum copay per case Exception: *Regence*, $1,200 maximum copay per case	50%; $750 lifetime maximum (dental plan payment)
Orthognathic surgery	70%; $5,000 lifetime maximum (dental plan payment)	70%; $5,000 lifetime maximum (dental plan payment)
Periodontic services	$50 copay, complete occlusal adjustment; $100 copay, osseous surgery per quadrant	80%, PPO and out of state; 70%, non-PPO (dental plan payment)
Preventive/ diagnostic	100% (dental plan payment)	100%, PPO; 90%, out of state; 80%, non-PPO (dental plan payment)
Restorative crowns	*DeltaCare*, $100 copay, porcelain crown; $175 copay, full or ¾ cast metal crown *Regence*, $140 copay, full or ¾ cast metal crown	50%, PPO and out of state; 40%, non-PPO (dental plan payment)
Restorative fillings	$10 copay, amalgam restorations (fillings), permanent teeth, two surfaces Exception: *Regence*, $0 copay	80%, PPO and out of state; 70%, non-PPO (dental plan payment)

UDP and Regence Dental General Exclusions

The following services are not covered:

1. Dentistry for cosmetic reasons. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.

2. Restorations or appliances necessary to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth.

3. Application of desensitizing medicaments.

4. Services or supplies that the plan determines are experimental or investigative. Determination is made according to the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.

a. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.

b. The provider has not demonstrated proficiency in the service, based on experience, outcome, or volume of cases.

c. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.

d. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to the enrollee's health or safety.

Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols, or scientific data from another provider studying the same service.

The documentation used to establish the plan's criteria will be made available for your examination at the office of the plan if you send a written request.

If the plan determines that a service is experimental or investigative, and therefore not covered, you may appeal the decision. The plan will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.

5. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as premedication and nitrous oxide.

6. General anesthesia, including intravenous and inhalation sedation (except when in conjunction with covered oral surgery, endodontic, and periodontal procedures–Uniform Dental Plan [UDP] only).

7. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirements are met:

a. A hospital setting for the dental care must be medically necessary.

b. Expenses for such care are not covered under the enrollee's employer-sponsored medical plan.

c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the plan. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.

If hospital or facility care is approved, available benefits will be provided at the same percentage rate as those performed by a participating dental provider, up to the available benefit maximum.

8. Dental services started prior to the date the person became eligible for services under this plan, except as provided for orthodontic benefits.

9. Services for accidental injury to natural teeth when evaluation of treatment and development of treatment plan is performed more than 30 days from the date of the accident.

10. Expenses incurred after termination of coverage, except expenses for:

a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.

b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.

c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.

11. Missed appointments.

12. Completing insurance forms or reports, or for providing records.

13. Habit-breaking appliances, except as specified under the orthodontia benefit.

14. Full-mouth reconstruction or dental implants.

15. Charges for dental services performed by anyone who is not a licensed dentist or physician, as specified.

16. Services or supplies that are not listed as covered.

17. Treatment of congenital deformity or malformations.

18. Orthodontic treatment, orthognathic treatment, and treatment of TMJ disorders that are not authorized in advance by the plan.

19. Replacement of lost or broken dentures or other appliances.

20. Services for which an enrollee has contractual rights to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowner's, or other no-fault insurance.

21. In the event a UDP enrollee fails to obtain a required examination from a UDP (Washington Dental Service) appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment. (UDP only)

22. UDP (Washington Dental Service) shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the contract, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.

DeltaCare General Exclusions

1. General anesthesia, including intravenous and inhalation sedation, and the services of a special anesthesiologist.

2. Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers, or tooth bleaching.

3. Services for injuries or conditions which are compensable under Workers' Compensation or Employers' Liability laws, and services which are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.

4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion, or erosion without sensitivity and restorations for malalignment of teeth.

5. Application of desensitizing agents.

6. Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/ observation. In determining whether services are experimental, DeltaCare (WDS), in conjunction with the American Dental Association, shall consider if: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause shall be notified of the denial within 20 working days of receipt of a fully documented request. Any denial of benefits by DeltaCare (WDS) on the grounds that a given procedure is deemed experimental, may be appealed to DeltaCare (WDS).

7. Dental services performed in a hospital and related hospital fees.

8. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures).

9. Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage.

10. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility.

11. Cysts and malignancies.

12. Laboratory examination of tissue specimen.

13. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide.

14. Cases in which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.

15. Prophylactic removal of impactions (asymptomatic, nonpathological).

16. Specialist consultations for non-covered benefits.

17. Implant placement or removal, appliance placed on or services associated with implants.

18. Orthodontic treatment which involves therapy for myofunctional problems, temporomandibular joint (TMJ) dysfunctions, micrognathia, macroglossia, cleft palate, or hormonal imbalances causing growth and developmental abnormalities.

19. All other services not specifically included on the patient's copayment schedule as a covered dental benefit.

20. Treatment of fractures and dislocations to the jaw.

21. Correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function (unless mandated by state law).

22. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DeltaCare (WDS) or as cited under "Out of Area Emergency Treatment."

Glossary

Annual deductible

The amount you pay each calendar year before the plan pays benefits for covered expenses. Most plans described in this booklet do not have an annual deductible, except for the UMP and some plans' extended network benefits. Some benefits may not apply to the annual deductible. Refer to your plan's certificate of coverage for details.

Annual out-of-pocket maximum

The most you would pay toward the majority of covered expenses in a calendar year. This means once you've reached your out-of-pocket maximum, most plans pay 100 percent of most covered expenses for the remainder of the calendar year. These expenses apply to the out-of-pocket maximum:

- Inpatient hospital admissions
- Ambulance service
- Outpatient/day surgery and ambulatory surgery centers
- Physical, occupational, and speech therapy
- Organ transplants
- Skilled nursing facility services

Extended network benefits and UMP benefits usually have different out-of-pocket limits from standard managed-care benefits. Refer to your plan's benefits booklet for details.

Certificate of coverage

A legal document that describes eligibility, covered services, limitations and exclusions, utilization procedures, and other plan provisions.

Coinsurance

The percentage you pay on claims for which your plan pays benefits at less than 100 percent.

Copays

The fixed cost you pay for services at the time you receive care. Most plans described in this guide require copays (sometimes called "copayments") when you see network providers or receive prescription drugs.

Emergency

Conditions with symptoms so severe that most people would reasonably expect that, without immediate health care attention, the condition would:

- Seriously jeopardize the individual's physical or mental health
- Seriously impair bodily functions
- Cause a serious dysfunction of any body organ or part

Your plan reserves the right to determine whether the symptoms indicate a medical emergency. See the plan's benefits booklet for details.

Hospice care

Medical, therapeutic, nursing, or counseling services for a terminally ill patient and family enrollees by a public or private agency or organization for that specific service.

Inpatient

A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maximum plan payment for medical plans

The total amount paid out by each PEBB-sponsored medical plan, on behalf of each covered individual for all benefits, is limited to a lifetime maximum plan payment of $1,000,000. Up to $10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by the plan during the prior calendar year. Some services are also subject to specific calendar year or lifetime benefit limitations, as detailed in each plan's benefit book.

Midyear

Any time other than the open enrollment period.

Network

A group of health care providers in a certain geographic location (including doctors, hospitals, and other health care professionals and facilities) who agree to provide services at negotiated rates.

Open enrollment period

The period of time each year during which you may change medical and/or dental plans and add to or drop family members from your coverage.

Outpatient

A patient who has not been admitted but is receiving covered services inside or outside a health care facility under a provider's direction.

Premium

The amount PEBB enrollees pay monthly for the cost of their health insurance. Premiums vary in cost depending on the health plan and the number of family members covered.

Primary care provider (PCP)

The doctor or nurse you choose to see for regular office visits, and who may refer you to and coordinate your care with specialists.

Many PEBB plans (except the UMP) require each enrollee have a primary care provider, who may be in family practice, internal medicine, or pediatrics. Women may also choose obstetricians or gynecologists for their PCP. However, each covered family member may have a different PCP. If you do not choose a PCP, some plans will choose one for you based on where you live. You may change your PCP during the year. The list of providers may be updated periodically.

Provider

A health care practitioner or facility operating within the scope of a license.

Specialist

A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Subnetwork

A provider group (such as a hospital) whose providers may restrict your choice of referred specialists to only those within that same provider group.